OFFICE OF POLICY AND LEGAL ANALYSIS
MEMORANDUM

TO: IFS Committee Members

FROM: Colleen McCarthy Reid, Legislative Analyst

DATE: January 3, 2012

RE: Federal Guidance Related to Essential Health Benefits

On December 16, 2011, the federal Department of Health and Human Services issued a bulletin to States on essential health benefits. A hard copy of the bulletin is attached as well as an issue brief outlining the impact of requiring essential health benefits on coverage in the individual market.

The bulletin outlines proposed policies that will give states considerably more flexibility and freedom in implementing the Affordable Care Act with regard to essential health benefits. Comments on the bulletin are being solicited until January 31, 2012.

Essential Health Benefits

Beginning in 2014, the ACA requires individual and small group health plans inside and outside of exchanges to cover the essential health benefits as defined by the Secretary of Health and Human Services. The essential health benefits package must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

Intended Approach: Selection of Benchmark Plan

HHS intends to propose that essential health benefits are defined using a benchmark approach. States would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This would give states the flexibility to select a plan that would best meet their needs.

States would choose one of the following benchmark health insurance plans:

- One of the three largest small group plans in the State by enrollment;
- One of the three largest State employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment;
- The largest HMO plan offered in the State's commercial market by enrollment.

If States choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the State.

The benefits and services included in the benchmark health insurance plan selected by the State would be the essential health benefits package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. To determine enrollment in plans for identifying the benchmark plan options, HHS proposes that states use enrollment data from the first quarter 2 years prior to the coverage year (the first quarter of 2012 for 2014 coverage year) and that States select their benchmark plan in the third quarter two years prior to the coverage year (the third quarter of 2012 for the 2014 coverage year).

Impact on State Mandates

To prevent Federal dollars going to State benefit mandates, the health reform law requires States to defray the cost of benefits required by State law in excess of essential health benefits for individuals enrolled in any plan offered through an Exchange. However, as a transition in 2014 and 2015, some of the benchmark options will include health plans in the State's small group market and State employee health benefit plans. These benchmarks are generally regulated by the State and would be subject to State mandates applicable to the small group market. Thus, those mandates would be included in the State essential health benefits package if the State elected one of the three largest small group plans in that State as its benchmark. State mandates outside the definition of essential health benefits may not be included in future years. HHIS intends to reevaluate the benchmark approach in calendar year 2016.

Coverage

Essential health benefits must include coverage of services and items in all 10 statutory categories. If a state selects a benchmark plan that does not cover all 10 categories of care, the state will have the option to examine other insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that must be included in the essential health benefits package. To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benchmark plan selected by the state and modified as necessary to reflect the 10 coverage categories. Health plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all 10 statutory EHB categories and the coverage has the same value.

Cost-Sharing

Especially with regard to exchange plans, the ACA distinguishes between a health plan's covered services, and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will be addressed in separate rules and will determine the actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60% actuarial value, silver at 70% actuarial value, gold at 80% actuarial value, and platinum at 90% actuarial value.